Safeguarding Adults Referral Guidance

For Falls In Care Homes

Solihull Safeguarding Adults Board
Protecting Adults Together

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Purpose of This Document

The purpose of this guidance is to support care home staff, safeguarding leads, and all practitioners in making the decision of when to make a referral to Adult Care and Support safeguarding, when a person has experienced a fall.

Prevention

The prevention of falls is the most important aspect of the safeguarding process. It is the care providers responsibility to ensure that they protect the people in their care from harm through having robust policies and procedures to prevent falls.

It is recommended that all new individuals are assessed for their potential to fall within 24 hours of admittance. Where there is a risk of falling, an Individualised Care Plan should be created to identify risks and mitigate where possible.

The Falls Prevention Team and Support to Care Homes Team have produced the Falls Tool Kit intended to support care providers to identify risks so that measures can be put in place that will reduce the incidence or recurrence of falls.

When to Raise a Concern Following a Fall

Please note: Where there is a possibility that a crime may have been committed, this must be immediately reported to the Police.

The care provider or other professional should consider if the incident has met one or more element(s) of the **2-stage criteria** when raising a safeguarding concern.

1. There is possibility that the person has experienced **avoidable harm** or there is a concern that actual or possible abuse was **caused by another.** (See categories below).

2. The harm experienced is considered **significant or severe injury**. (See categories below).

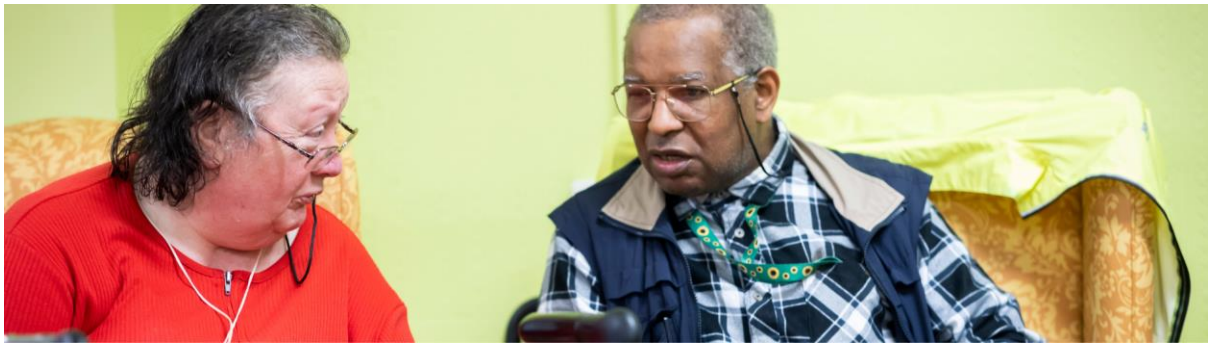
Where no significant harm has occurred, but a person has sustained a number of falls, this should also be referred to safeguarding. A general guidance would be where a person has fallen **3 or more times in 3 months**.

Avoidable Harm

Not Avoidable	Avoidable Harm	Avoidable Harm High Risk
Not Safeguarding	Safeguarding referral required	Urgent action is required to safeguard the person or others
The likelihood of a fall could not have been predicted. There is no or a low likelihood that the harm will re-occur.	There are indications that the fall may have been caused by another person or if the fall could have been avoided, was the consequence of omission or neglect or high risk continues	There is a high likelihood of ongoing harm to the person or others (resulting from one-off or re-occurring severe incidents).

Significant Injury

Minor Injury	Significant Injury	Severe Injury
No safeguarding referral required Fall resulted in a minor injury. Resident does not require a skilled medical response. Small level of bruising or light surface wounds, no head injury, or loss of consciousness. Possibly seen by paramedic, but not requiring hospital admission.	Safeguarding referral required Injury requiring a skilled medical response (possibly requiring an inpatient admission to hospital) but where the person is expected to fully recover. Typically, skin tears or cuts requiring stitches or wound management. Multiple or extensive bruising to face or body. Minor head injury with no loss of consciousness.	Safeguarding referral required Injury resulting in potential disability or ongoing significantly increased care and support needs. Typically bone fracture, particularly legs/hip, significant head or injury, or loss of consciousness.



Safeguarding Concerns

Examples of situations when a safeguarding concern should be raised after a fall include:

- Significant injury
- Fall was caused by another person with care and support needs
- Repeated falls despite preventative advice
- A series of unexplained or minor injuries
- No falls risk assessment or care plan in place (avoidable harm)
- Falls risk assessment or care plan has not been updated
- No appropriate medical intervention sought or given after a fall.
- Environmental hazards, such as poor lighting or clutter, equipment left out, wet floors, resulting in a fall and injury
- A fall as a result of safety equipment not in working order, not being issued or not used correctly.
- Fall and injury as a result of medication mismanagement
- Fall as a result of poor monitoring or low staffing
- Members of staff not receiving training in falls management and/or not adhering to the falls policy and protocols following a fall

Questions You Are Likely to Be Asked When You Raise Your Concern to the Local Authority:

- What happened, where, and when?
- Was the fall witnessed or unwitnessed?
- Does the person have mental capacity?
- Has the person been checked by staff for any injuries?
- Has the person been injured in the fall?
- If there is injury, has the person been seen by a medical professional or has medical advice been sought? How long after the fall did this happen?
- If the person has been seen by a medical professional, what is their view on the injury/bruising (e.g. unusual or concerning)?
- How many falls or similar has the person had in the last 6 months?

- When was their last fall? What management plan was put in place after this? (e.g. any specialist equipment, referrals to outside agencies, any regular monitoring – consider night as well as daytime monitoring).
- If a care plan is in place, is there documentation to show the plan was being followed?
- What has been done now to prevent or minimise risk of further falls for the person?
- Has the family or advocate been advised of the fall and action taken by the provider?

To report concerns you may have about a fall as safeguarding:

- Use the online reporting form - solihull.gov.uk/Report-safeguarding
- Phone the One Front Door duty team on **0121 704 8007**

The social worker will consider the information gathered against the Harm Descriptor Tool

When the Concern Progresses to a S42 Safeguarding Enquiry

Where it is suspected a crime may have been committed, the first responsibility of those involved in the care of an adult who has experienced abuse is to report the incident to the Police

Section 42 of the Care Act 2014 defines the duty of the Local Authority to protect people with care and support needs from abuse.

(Section 42) requires that each Local Authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

In its simplest form, the purpose of a (S42) Safeguarding Enquiry in relation to falls is therefore to:

- Identify the factors that led to the person falling
- Establish the person's outcomes and what they want to happen

- Determine what learning and actions need to be taken to reduce the risk of further falls or abuse

A Safeguarding Enquiry is most successful when the person with lived experience is at the centre of the process and their outcomes are fully understood. The person's consent to proceed to enquiry will usually be requested, however the safeguarding process is not dependent on the person's consent. Where the person is unable to consent, has died, or where there is information that indicates others may be at risk, the Local Authority may still proceed with Safeguarding Enquiry processes.

For a fall to be investigated under statutory safeguarding processes it is likely to be considered under on the following four categories. How the abuse is categorised will often shape how the enquiry is conducted.

Physical Abuse

Someone pushed / hit / tripped / barged the adult which resulted in the fall.

Neglect & Acts of Omission

- Care plans not followed
- Checks not completed
- Failure to assess / recognise and respond to need (e.g. where there has been a significant history of falls with no action taken).

Organisational Abuse

Systems have failed to support safe care, including:

- Lack of staff
- Untrained staff
- Care plan reviews not completed
- Information not communicated effectively

Self-Neglect

Fall occurred because the person is not caring for themselves, or their environment, or refusing help. Consider the mental capacity of the person to make decisions or decline support.

Scope of The S42 Enquiry

The scope of any safeguarding enquiry, its nature, and how long it takes, will depend on individual circumstances. It will usually start with a social worker asking the adult their view and wishes, which will often determine the next steps to take. Everyone involved in an enquiry should focus on improving the adult's wellbeing and work together to that shared aim.

The social worker allocated to lead the enquiry will contact the person and all relevant parties involved in the person's care. They may include professionals not previously involved in the person's care to gain expert opinion or support.

The social worker will write a report on their findings which will look at the circumstances of the abuse, what the person wanted to happen as a results of their experience, and learning from the abuse which can be applied to the person's care planning or the care of others to minimise the risk of further abuse.

The information and learning from the enquiry are most likely to be shared within a Multi-Agency Safeguarding Case Conference. Where the person or their family / representative does not want a case conference, the report and its outcomes will be shared directly with the person, their key workers, and their family as appropriate.

Other Agencies That Must Be Informed After a Fall

Clinical Commissioning Group (CCG) Serious Incident Procedure

Where the 'severe injury' descriptors are met, the care home manager or safeguarding lead must also notify the Clinical Commissioning Group (CCG) and undertake a Serious Incident investigation.

Click here to report a serious incident to the CCG

Questions you are likely to respond to in a Serious Incident enquiry:

- Does the resident have a history of falls?
- Was a falls risk assessment in place?

- What was the assessed level of risk of falling?
- Was the homes policy on management of falls followed?
- What observations took place after the fall?
- Did the resident attend hospital?
- What was the outcome of hospital attendance?
- What Learning has been taken from the incident?

Reporting a Concern to Care Quality Commission (CQC)

All care homes are required by law to report any issues or incidents that may affect a person's health or wellbeing. The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Seven Reporting Requirements

Providers must tell the CQC of any allegations of abuse in their service. This requirement is tied to the need for providers to ensure they are safeguarding their service users.

1. Abuse or allegations of abuse
2. Serious injuries
3. Applications to deprive a person of their liberty
4. Events that prevent of threaten to prevent the registered person from carrying on an activity safely and to an appropriate standard
5. Deaths of service users
6. Incidents reported to, or investigated, by the Police
7. Unauthorised absences

Click here for further information on how to notify CQC

Phone - 03000 61 61 61
Monday to Friday – 8:30am to 5:30pm
(Excluding Bank Holidays)

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